Minutes of the meeting of the Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System held Tuesday, August 16, 2016 at the hour of 10:30 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Gugenheim called the meeting to order.

Present: Chairman Ada Mary Gugenheim and Directors Mary Driscoll, RN, MPH and Wayne M. Lerner, DPH, LFACHE (3)

Board Chairman M. Hill Hammock (ex-officio) and Director Emilie N. Junge

Patrick T. Driscoll, Jr. (non-Director Member)

Absent: Director Layla P. Suleiman Gonzalez, PhD, JD (1)

Additional attendees and/or presenters were:

Debra Carey – Chief Operating Officer, Ambulatory Services
Krishna Das, MD – Chief Quality Officer
Jeff McCutchan – Interim General Counsel
Deborah Santana – Secretary to the Board
John Jay Shannon, MD – Chief Executive Officer

II. Public Speakers

Chairman Gugenheim asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

III. Report from Chief Quality Officer

A. Regulatory and Accreditation Updates
B. Metrics (Attachment #1)
C. Culture of Safety Survey – Stroger 2015 (Attachment #2)

Dr. Krishna Das, Chief Quality Officer, provided information on three (3) regulatory and accreditation matters. She stated that the administration was just notified that Stroger Hospital's stroke program certification visit will take place next Wednesday; this is a one (1) day survey for certification as a primary stroke center. Staff continue their preparations for the Ambulatory survey by The Joint Commission; it will be conducted approximately three to four months from now. The administration is also expecting a survey by the College of American Pathology of the laboratories at Stroger Hospital; it is anticipated that the visit will take place sometime in the fall.

With regard to metrics relating to patient satisfaction, Lerner requested that Committee receive a report on the open-ended comments provided by patients in response to the patient survey. Dr. Das responded that this can be done.

With regard to the metrics on immunizations of children, Dr. Das stated that several initiatives are being structured to improve the rates. She will ask the pediatricians to analyze the metrics to ascertain the reason(s) for the rate decline and will report back to the Committee.

III. Report from Chief Quality Officer (continued)

Director Driscoll inquired regarding whether data is available on diabetic patients, for example, who show up in the emergency room or who have been hospitalized in the past year. Dr. Das stated that this question has been discussed, but it has been a challenge to define what would be considered "existing" patients. With regard to the question of how many patients are in ACHN and are enrolled in some form of primary care who show up at the emergency room or in the hospital, Dr. Das indicated that those numbers should be available; she will follow up and report back to the Committee.

Dr. Das reviewed the Culture of Safety Survey presentation, which included information on the following subjects:

- Joint Commission Standard
- Culture of Safety Dimensions
- CCHHS Survey Results
  - Tenure in Hospital
  - Staff Position
  - Mean Scores
  - Domain Scores
  - Priority Index Scores
- Characteristics of a Safe Culture
- Trust-Report-Improve Cycle
- Number Events Reported 12 Months
- Future Directions

During the discussion of the information, Dr. Das provided additional details on the administration's efforts to increase the rate of response. Director Lerner inquired regarding whether written surveys are available for those employees who are not computer-savvy. Dr. Das responded in the negative, but stated that this is a good idea. Director Lerner suggested that the administration consider the idea of setting up kiosks in certain areas for employees to use to complete the survey; additionally, he suggested that the administration look at the response rate by shift, as this can provide further insight and information.

IV. Action Items

A. Approval of 2016 Quality Assessment and Performance Improvement Plan for John H. Stroger, Jr. Hospital of Cook County (presentation on the subject was received in February 2016) (Attachment #3)

Dr. Das provided a brief overview of the proposed 2016 Quality Assessment and Performance Improvement Plan for Stroger Hospital. She noted that the Committee previously received information on the subject at its meeting in February but did not receive the full text of the Plan at that time. It is expected that the Provident Hospital Quality Assessment and Performance Improvement Plan will be presented in the near future.

Included in the presentation was information on the following subjects:

- Goals of a Quality Program;
- Regulatory Standards;
- Organization of the Quality Program;
- Inpatient Quality 2015;
- Outpatient Quality 2015;
- Patient Safety 2015;

IV. Action Items

A. Approval of 2016 Quality Assessment and Performance Improvement Plan for John H. Stroger, Jr. Hospital of Cook County (continued)

- Patient Experience 2015;
- Ensuring Accountability;
- Improve Culture of Safety;
- Requirements for Quality Indicators;
- Dashboard Categories;
- Key Performance Indicators;
- Reports to Hospital Quality Committee;
- Structure and Members of Quality Committee; and
- Quality Reporting.

During the discussion of the presentation, additional information was presented regarding health risk assessments and population health management. Debra Carey, Chief Operating Officer, Ambulatory Services, stated that health risk assessments are conducted on all of the patients who come to the ACHN clinics. The assessment includes not only the clinical aspect, but also includes the assessment of social determinants of health, such as housing. Staff are currently in the process of developing a report of these results. This year's initial assessment will provide a baseline for ACHN; each year, there will be an update to that assessment.

> Director Lerner, seconded by Director Driscoll, moved to approve the 2016 Quality Assessment and Performance Improvement Plan for John H. Stroger, Jr. Hospital of Cook County. THE MOTION CARRIED UNANIMOUSLY.

B. Executive Medical Staff (EMS) Committees of Provident Hospital of Cook County and John H. Stroger, Jr. Hospital of Cook County

i. Receive reports from EMS Presidents

There were no reports received from EMS Presidents at this meeting.

ii. Approve Medical Staff Appointments/Re-appointments/Changes (Attachment #4)

> Director Lerner, seconded by Director Driscoll, moved to approve the Medical Staff Appointments/Reappointments/Changes relating to Stroger Hospital medical staff action items. THE MOTION CARRIED UNANIMOUSLY.
>
> Director Lerner, seconded by Director Driscoll, moved to approve the Medical Staff Appointments/Reappointments/Changes relating to Provident Hospital medical staff action items. THE MOTION CARRIED UNANIMOUSLY.

C. Minutes of the Quality and Patient Safety Committee Meeting, July 19, 2016

> Chairman Gugenheim, seconded by Director Lerner, moved to accept the Minutes of the Quality and Patient Safety Committee Meeting of July 19, 2016. THE MOTION CARRIED UNANIMOUSLY.

D. Any items listed under Sections IV and V

V. Closed Meeting Items

A. Medical Staff Appointments/Re-appointments/Changes
B. Litigation Matter(s)

The Committee did not recess the open meeting and convene in a closed meeting.

VI. Adjourn

As the agenda was exhausted, Chairman Gugenheim declared the meeting ADJOURNED.

Respectfully submitted,
Quality and Patient Safety Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXX
Ada Mary Gugenheim, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

COOK COUNTY HEALTH & HOSPITALS SYSTEM

CCHHS Board of Directors
Quality and Patient Safety Committee
Dashboard Overview

16 August 2016

Krishna Das, MD, Chief Quality Officer

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Quality – Stroger

CCHHS QPS Committee Dashboard															
Data as of 8/12/16	CY 2015							CY2016						TARGET	VARIANCE *
PERFORMANCE MEASURES	Q2 2015	Q3 2015			Q4 2015			Q1 2016			Q2 2016				
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June		
Stroger															
Core Measures															
Venous Thromboembolism (VTE) Prevention Only (%)	92	95	91	82	93	87	93							99	-6%
Venous Thromboembolism (VTE) Prevention & Treatment (%)	86	84	91	83	93	91	94							99	-5%
Care for Stroke Patients (%)	91	94	91	88	89	91	91	93	95	96	91	95	95	100	-5%
Influenza and Pneumococcal Vaccination (%)	26	38	54	45	67	59	60	72	63	76	67	67	79	90	-11%
Efficiency - Operating Room															
Surgery Begins at Scheduled Time (%)	50*	52*	60*	55*	52*	46*	46*	40*	46*	53*	65*	59*	56*	80	-24%
OR Room Turn Around Time (minutes)	45*	43*	42*	46*	45*	49*	47*	48*	50*	47*	47*	46*	47*	30	57%

LEGEND
* Data represents automated collection
* Variance is target to recent month
* N/S: Not Sufficient data collected

Quality – Provident

CCHHS QPS Committee Dashboard															
Data as of 8/12/16	CY 2015							CY2016						TARGET	VARIANCE *
PERFORMANCE MEASURES	Q2 2015	Q3 2015			Q4 2015			Q1 2016			Q2 2016				
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June		
Provident															
Core Measures															
Venous Thromboembolism (VTE) Prevention Only (%)	100	100	94	94	100	100	89							99	-10%
Venous Thromboembolism (VTE) Prevention & Treatment (%)	100	100	93	100	100	100	89							99	-10%
Influenza and Pneumococcal Vaccinations (%)	95	91	97	97	99	97	100	100	100	100	100	100	93	90	3%
Efficiency - Operating Room															
Surgery Begins at Scheduled Time (%)	81	80	89	84	80	81	88	72	70	79	76	79	78	80	-2%
OR Room Turn Around Time (minutes)														30	na

LEGEND
* Data represents automated collection
* Variance is target to recent month
* N/S: Not Sufficient data collected

Safety – Stroger

CCHHS QPS Committee Dashboard															
Data as of 8/12/16	CY 2015							CY2016						TARGET	VARIANCE *
PERFORMANCE MEASURES	Q2 2015	Q3 2015			Q4 2015			Q1 2016			Q2 2016				
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June		
Safety															
HAC: Pressure Ulcer Stages III & IV[1]	7	1	7	3	4	3	8	6	8	8	9	4	6		
HAC: Falls with Injury[2]	2	1	1	1	1	6	4	1	0	0	2	0	0		
HAI: CLABSI [3]	0	0	0	0	1	1	2	1	1	0	2	1	1		
HAI: CAUTI [4]	2	6	0	4	0	0	0	2	1	0	1	2	4		

LEGEND
CLABSI: Central line-associated blood stream infections
CAUTI: Catheter-associated urinary tract infections
*Variance is target to recent full quarter

Patient Experience – Stroger

CCHHS QPS Committee Dashboard															
Data as of 8/12/16	CY 2015							CY2016						TARGET	VARIANCE *
PERFORMANCE MEASURES	Q2 2015	Q3 2015			Q4 2015			Q1 2016			Q2 2016				
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June		
Patient Experience															
Willing to Recommend Hosp (% top box)	67	66	73	68	70	75	65	72	69	75	69	80	69	85	-16%
Communication with Doctors (% top box)	82	83	83	82	80	81	81	84	87	83	90	87	81	88	-7%
Communication with Nurses (% top box)	72	71	70	70	67	70	70	67	79	100	74	81	69	86	-17%
Cleanliness (% top box)	50	51	53	48	47	58	56	49	55	75	52	60	61	77	-16%

LEGEND
* Data represents automated collection
* Variance is target to recent month
* N/S: Not Sufficient data collected

Patient Experience – Provident

CCHHS QPS Committee Dashboard															
Data as of 8/12/16	CY 2015							CY2016						TARGET	VARIANCE *
PERFORMANCE MEASURES	Q2 2015	Q3 2015			Q4 2015			Q1 2016			Q2 2016				
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June		
Patient Experience															
Willing to Recommend Hosp (% top box)	71	83	58	50	80	100	100	100	N/S*	67	71	N/S*	N/S*	85	-14%
Communication with Doctors (% top box)	86	90	77	86	100	100	100	100	N/S*	100	95	N/S*	N/S*	88	7%
Communication with Nurses (% top box)	85	100	72	61	100	89	100	100	N/S*	100	91	N/S*	N/S*	86	5%
Cleanliness (% top box)	58	86	67	50	100	100	50	100	N/S*	83	57	N/S*	N/S*	77	-20%

LEGEND
* Data represents automated collection
* Variance is target to recent month
* N/S: Not Sufficient data collected

ACHN

CCHHS QPS Committee Dashboard															
Data as of 8/12/16	CY 2015							CY2016						TARGET	VARIANCE *
PERFORMANCE MEASURES	Q2 2015	Q3 2015			Q4 2015			Q1 2016			Q2 2016				
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June		
ACHN															
Diabetes Control % with Hgb A1C < 9%	74	77	76	76	76	76	73	75	72	74	73	73	75	78	-3%
Immunizations: Up to date in children at 24 months (%)	74	82	81	77	94	90	75	82	84	81	85	75	70	86	-16%
Patient Experience: Moving Through Visit	61	59	59	61	61	67	60	66	61	65	62	59	70	75	-5%
Patient Experience: Telephone Access	61	60	60	60	61	70	57	64	62	60	60	56	65	75	-10%

Board Quality Dashboard

CCHHS QPS Committee Dashboard	CCHHS Board Metrics - Quality						
Data as of 8/12/2016							
PERFORMANCE MEASURES	CY 2015			CY 2016		TARGET	VARIANCE*
	2Q15	3Q15	4Q15	1Q16	2Q16		
Stroger							
Core Measures	**Monthly Composite**						
Venous Thromboembolism (VTE) Prevention Only (%)	92	89	88			99%	-11%
Venous Thromboembolism (VTE) Prevention & Treatment (%)	86	86	93			99%	-6%
Efficiency - Operating Room	**Monthly %**						
Surgery Begins at the Scheduled Time (%)	50*	56*	48*	46*	60*	80%	-20%
Safety	**Total # of Events**						
Events: Ulcers, Falls, CLABSI and CAUTI	33	24	30	28	32		
Patient Experience							
Willing to Recommend Hosp (% top box)	66	69	71	70	72	85%	-13%
Provident							
Core Measures							
Venous Thromboembolism (VTE) Prevention Only (%)	94	96	98			99%	-1%
Venous Thromboembolism (VTE) Prevention & Treatment (%)	95	97	98			99%	-1%
Efficiency - Operating Room	**Monthly %**						
Surgery Begins at the Scheduled Time (%)	65	84	83	74	78	80%	-2%
Patient Experience							
Willing to Recommend Hosp (% top box)	68	52	89	78	N/S*	85%	-7%
ACHN							
Diabetes Control % with Hgb A1C < 9%	74	76	77	74	75	78%	-3%
Patient Experience: Moving Through Visit	63	60	63	64	64	75%	-11%
Patient Experience: Telephone Access	61	60	63	62	60	75%	-15%

LEGEND
* Data represents automated collection
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* N/S: Not Sufficient data collected

ATTACHMENT #2

COOK COUNTY HEALTH & HOSPITALS SYSTEM

Culture of Safety Survey

CCHHS Board of Directors
Quality and Patient Safety Committee

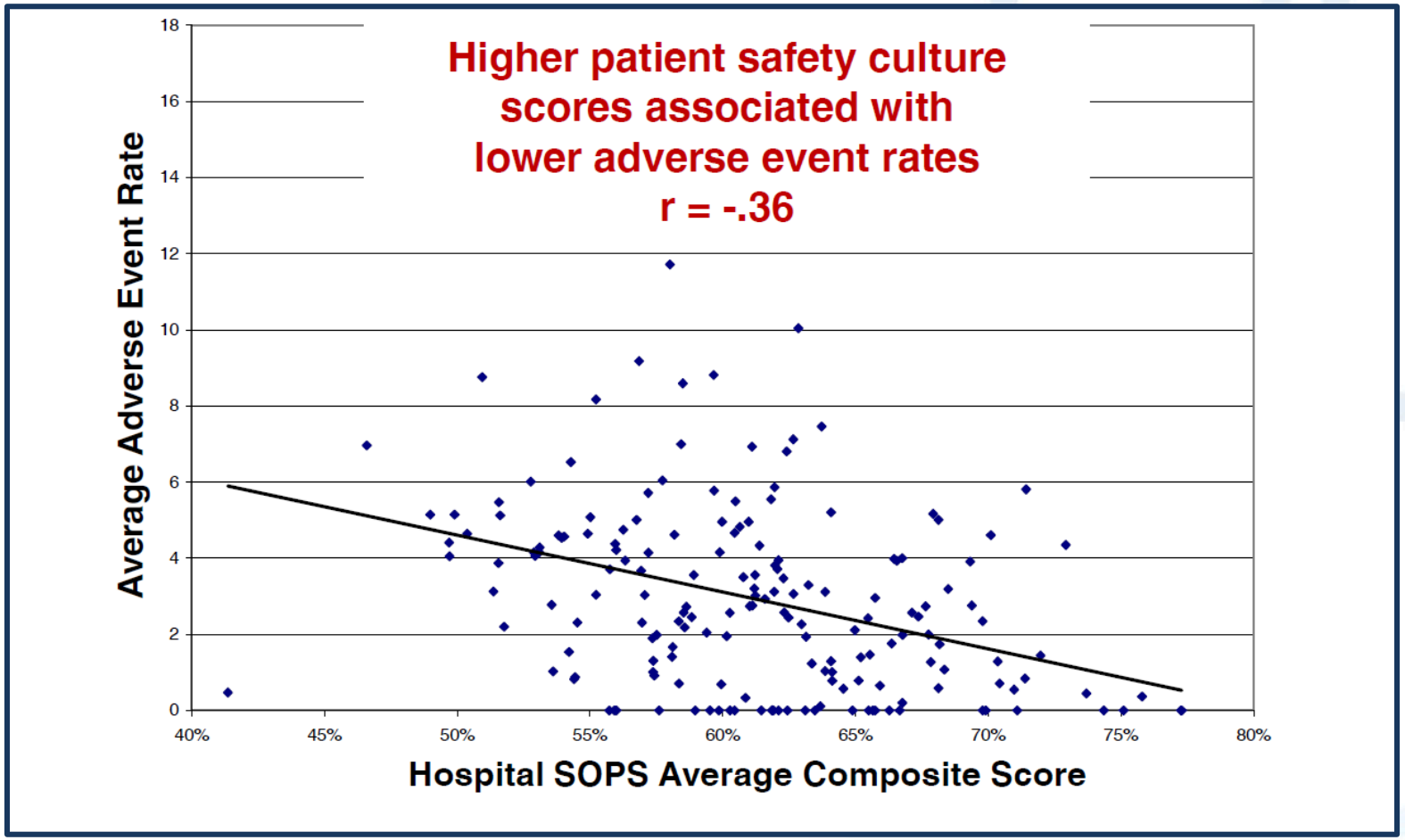
COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Why Emphasize Culture of Safety?

- Continuous improvement requires a learning culture
- Staff reporting of safety events leads to opportunities for improvement
- Staff must know they will not be punished for reporting safety events
- When safety issues are resolved, reporters should get feedback (and thanks!)

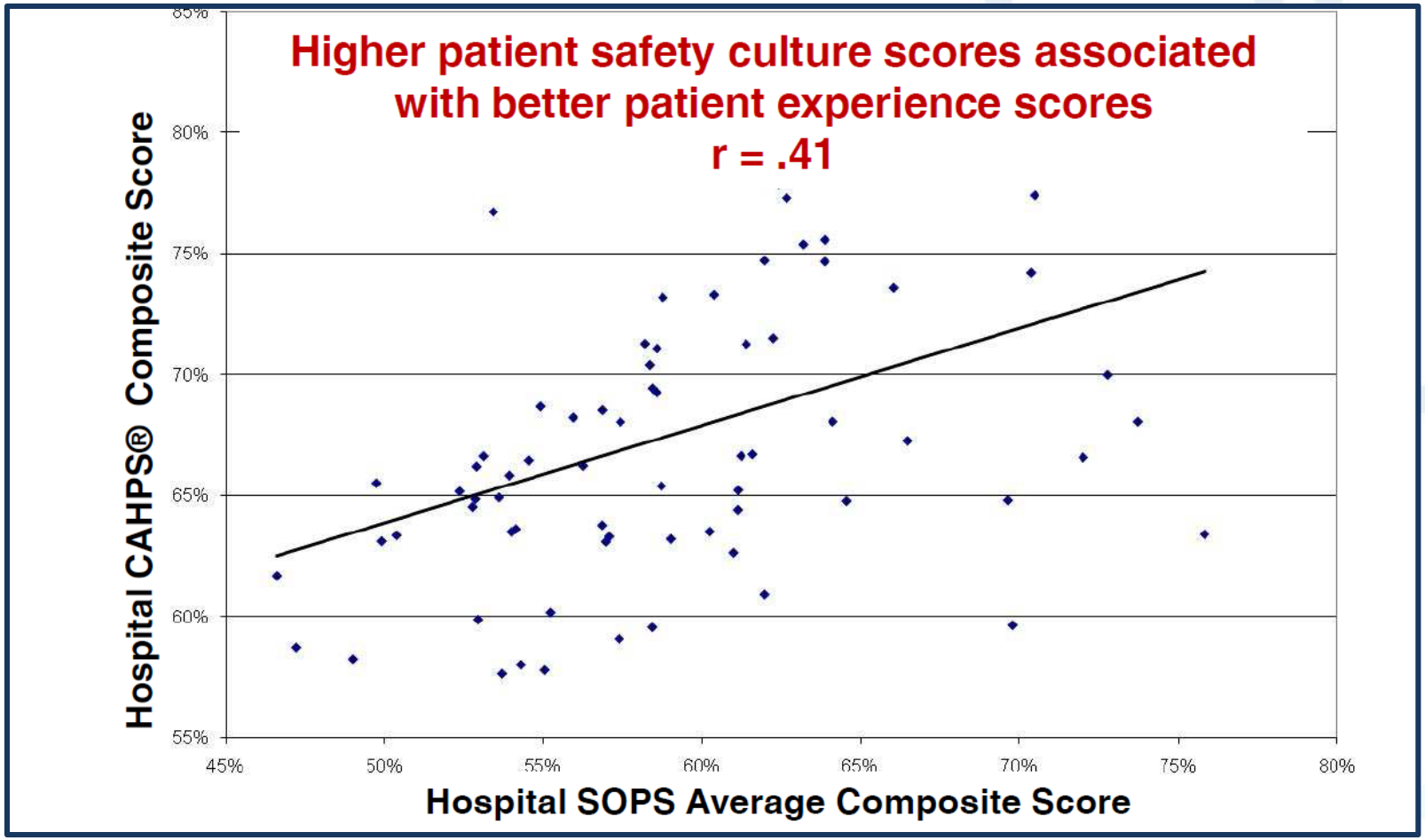
A Positive Culture = Patient Safety

Safety Culture and Patient Safety



Mardon et al. Dec 2010. Relation between safety culture and adverse events. J Pat Safety, 6(4):226-232

Safety Culture and Patient Satisfaction



Mardon et al. Dec 2010. Relation between safety culture and adverse events. J Pat Safety, 6(4):226-232

Joint Commission Standard

LD.03.01.01

Leaders create and maintain a culture of safety and quality throughout the hospital.

Rationale:

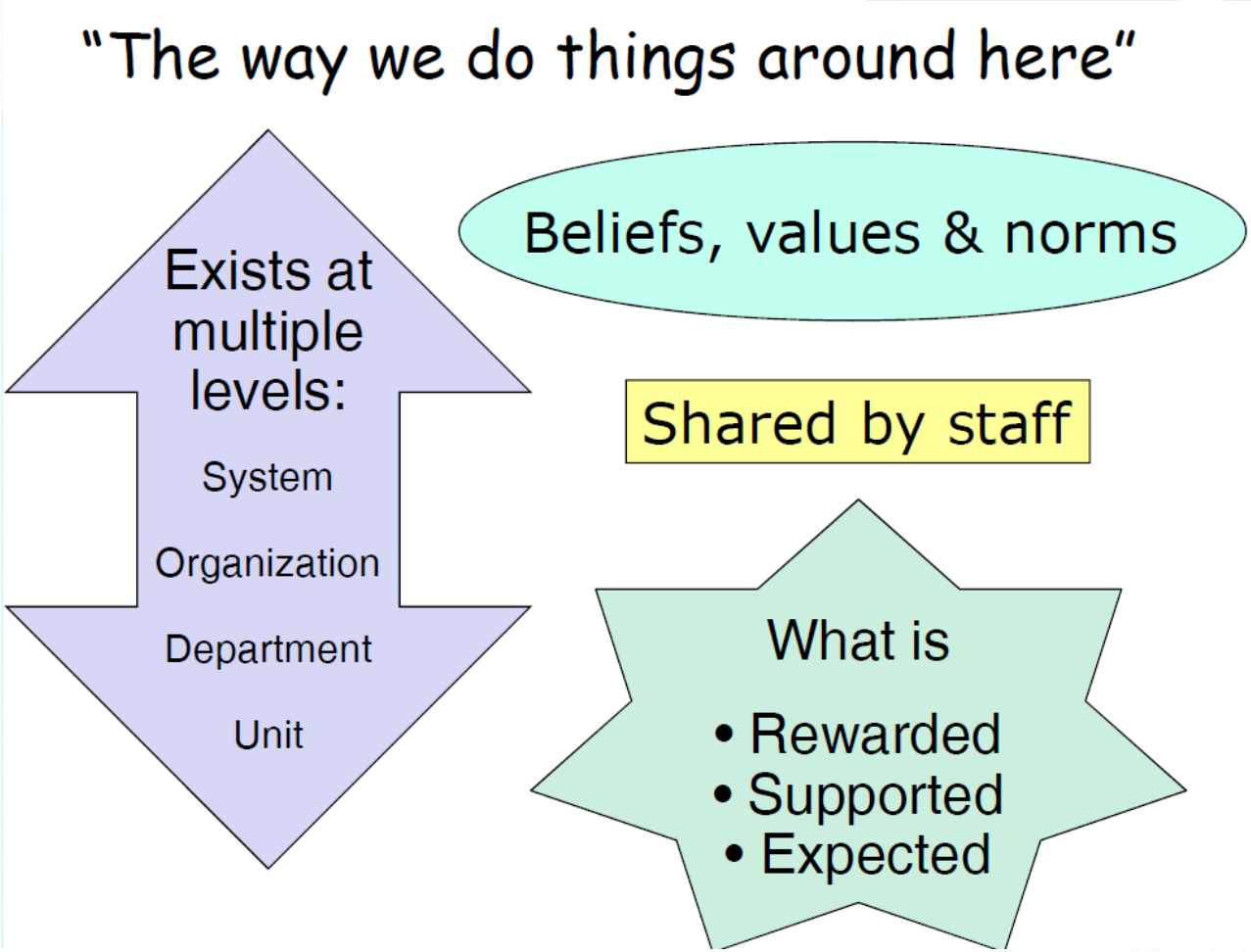
Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the hospital. Leaders demonstrate their commitment to quality and set expectations for those who work in the hospital. Leaders evaluate the culture on a regular basis.

Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to patient care. Leaders must address disruptive behavior of individuals working at all levels of the hospital, including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

Elements of Performance:

	DESCRIPTION	MOS	CR	DOC	SC	ESP
1	Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.				A	
2	Leaders prioritize and implement changes identified by the evaluation.				A	
3	Leaders provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives.				A	

Culture…


"The way we do things around here"
Exists at multiple levels:
System
Organization
Department
Unit
Beliefs, values & norms
Shared by staff
What is
• Rewarded
• Supported
• Expected

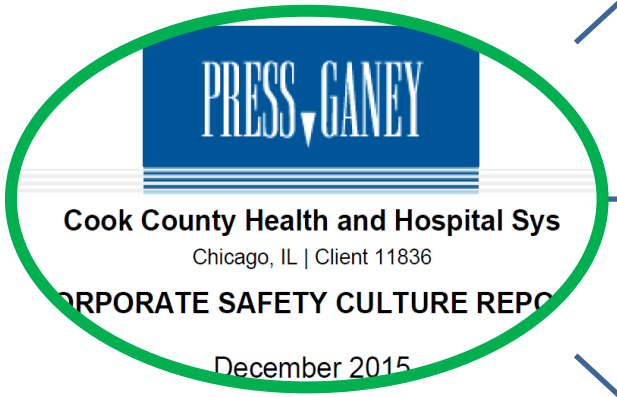
Culture of Safety Survey

- Communication Openness
- Feedback/Communication About Errors
- Frequency of Events Reported
- Handoffs and Transitions
- Hospital Management Support
- Non-Punitive Response to Error
- Organizational Learning
- Overall Perception of Safety*
- Overall Ratings*
- Staffing
- Teamwork Across Units
- Teamwork Within Units*
- Your Supervisor/Manager

CCHHS Survey

Survey Completed

- December2015



Fifty Eight Questions

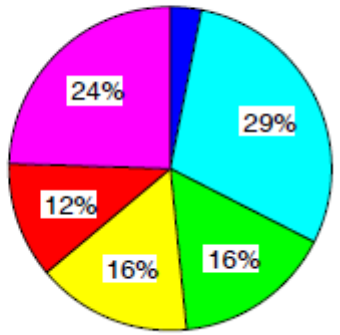
844 responses across the system = 11%

Eight Survey Sections

- 13 Dimensions

Tenure in Hospital

Question Response	Last Period *n*	 %	This Period *n*	 %
How long worked in this hospital				
Less than 1 year			26	3
1 to 5 years			246	29
6 to 10 years			133	16
11 to 15 years			130	16
16 to 20 years			97	12
21 years or more			205	24
Total			837	

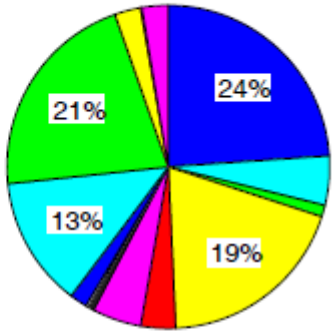


Staff Position

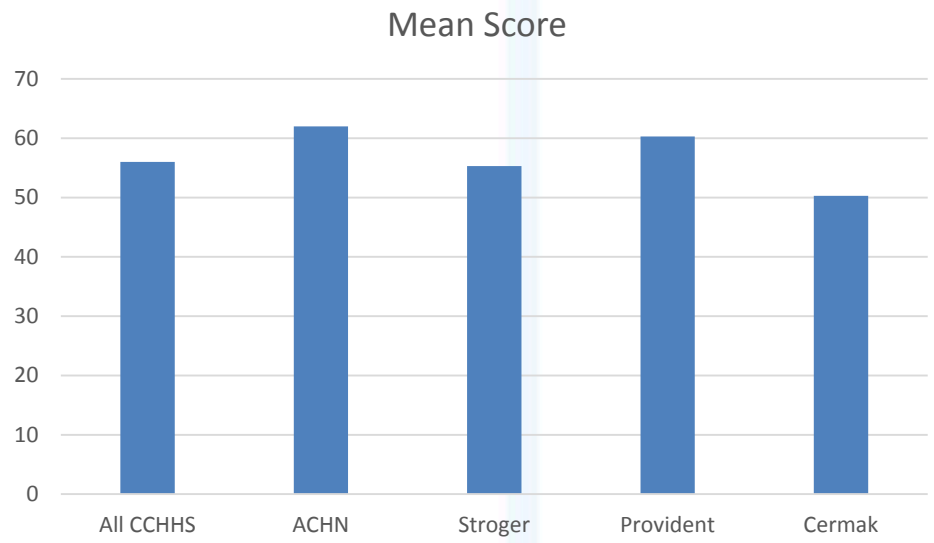
Question Response	Last Period *n*	Last Period %	This Period *n*	This Period %
What is your staff position				
RN			165	24
PA/NP			34	5
Pt Asst			8	1
Att Phys			133	19
Res			24	3
Pharm			34	5
Diet			4	1
Rsp Thrp			2	0
Ph/Oc/Sp			12	2
Adm/Mgt			90	13
Other			147	21
MedSW			18	3
HkpgEVS			1	0
Psych			18	3
Total			690	

Last Period

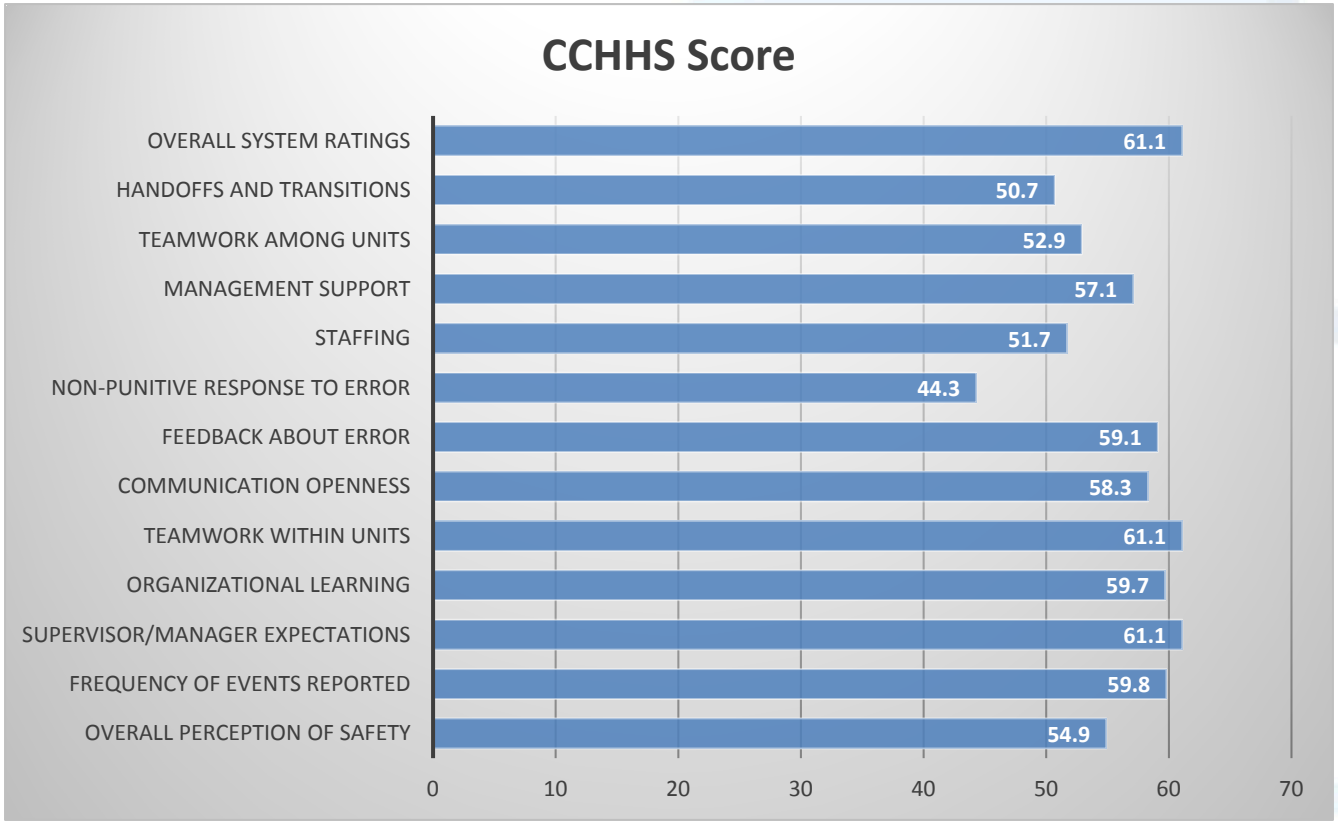
This Period



Mean Scores – CCHHS



Domain Scores – CCHHS



Priority Index Scores

	Priority Index Question	Dimension	Priority Index	Periods in Top 10
1	We are given feedback about changes put into place based on events	Feedback/Communica	75	1
2	I would feel safe being treated as a patient here.	Overall Ratings	72	1
3	After we make changes we evaluate their effectiveness.	Org. Learning	67	1
4	Hospital units do not coordinate well with each other.	Teamwork Across Units	66	1
5	Hospital management provides a climate of patient safety.	Hospital Management	64	1
6	Staff feel free to question the decisions of those with more authority.	Communication	63	1
7	Overall, the culture at this facility encourages patient safety.	Overall Ratings	62	1
8	My supervisor considers staff suggestions to improve patient safety.	Supervisor/Manager	61	1
9	I would recommend [this facility] to my friends and relatives.	Overall Ratings	60	1
10	Hospital units work well together to provide care for patients.	Teamwork Across Units	58	1

Priority Index

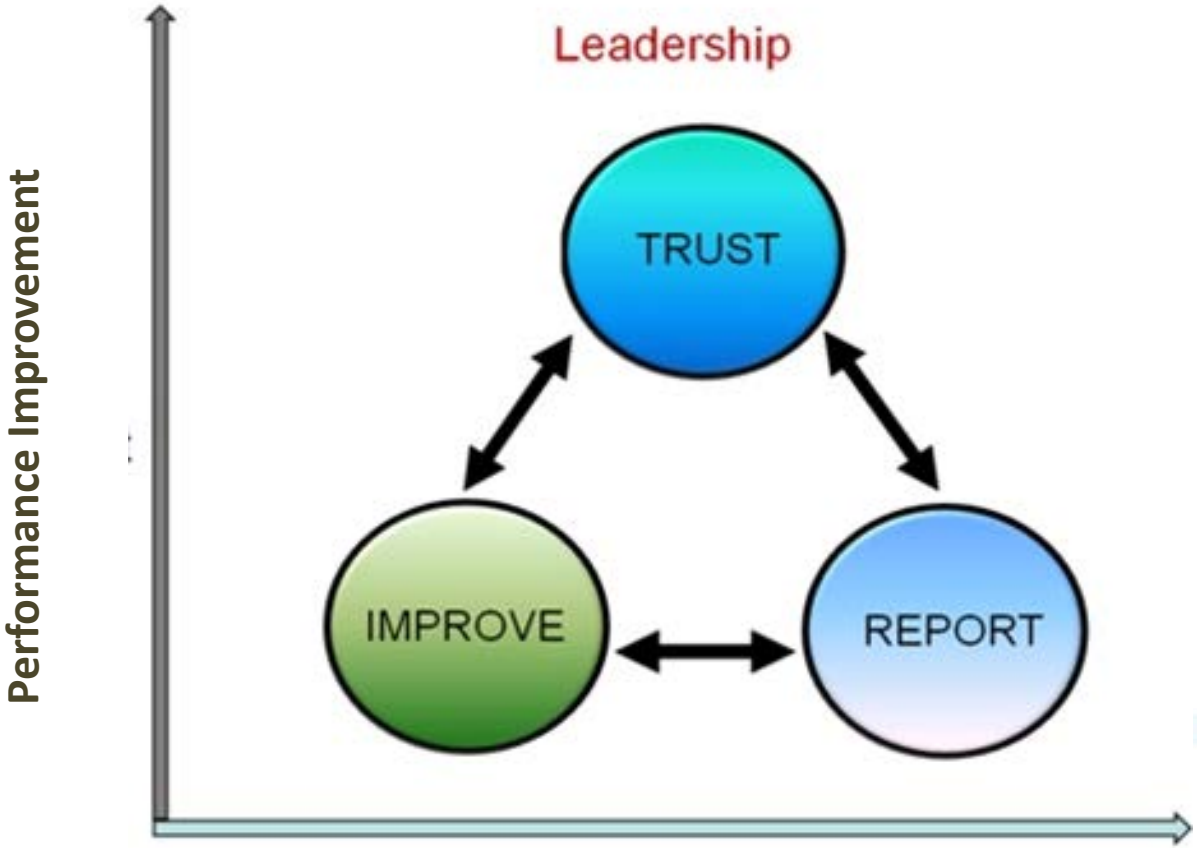
The Internal Priority Index combines information about your system's performance and the relative importance of each question to respondents' overall assessment of safety culture. Higher priority is given to those issues that are relatively important to respondents (high correlation coefficients) and that you scored low on (low mean scores). Questions are listed in decreasing priority. Pay particular attention to questions that are consistently among your top ten priorities. ***Questions that are among this period's top ten priorities appear in bold italics in this and previous sections of the report.***

Current Order	Previous Order	Periods Top 10	Question	Mean Score	Correlation Coefficient	Priority Index
1	-	1	***Get feedback about changes***	52.6 (35)	.67 (40)	35 40 75
2	-	1	***Feel safe being treated as patient***	56.2 (26)	.72 (44)	26 44 70
3	-	1	***Staff question decisions***	50.2 (38)	.61 (30)	38 30 68
3	-	1	***Units coordinate with each other***	42.9 (46)	.58 (22)	46 22 68
5	-	1	***Evaluate patient safety improvemnts***	55.6 (27)	.66 (39)	27 39 66
6	-	1	***Recommend to friends, relatives***	58.5 (21)	.69 (43)	21 43 64
7	-	1	***Mistakes have led to pos changes***	54.9 (28)	.61 (33)	28 33 61
7	-	1	***Supr/Mgr consider staff suggestions***	58.5 (20)	.68 (41)	20 41 61
7	-	1	***Hosp manage promotes pt safety***	60.4 (16)	.73 (45)	16 45 61
7	-	1	***Culture encourages patient safety***	60.7 (14)	.77 (47)	14 47 61

Characteristics of a Safe Culture

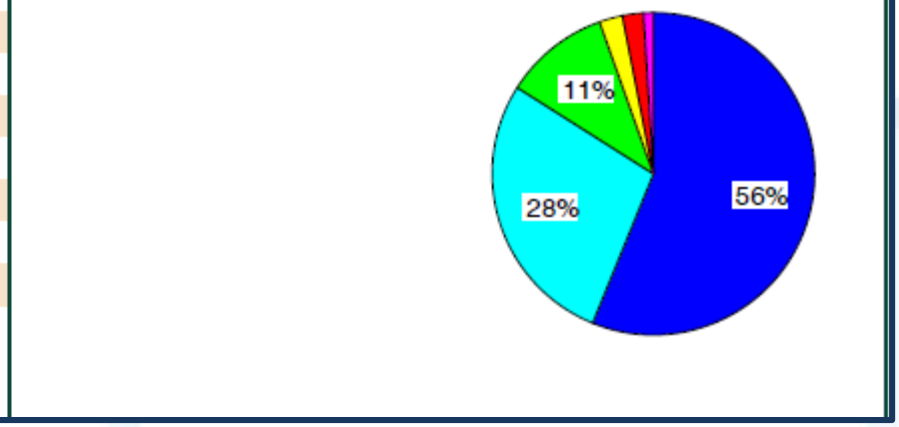
- Shared understanding – shared purpose
- Behavioral standards – uniformly applied
- Just environment – ‘just culture’
- Open communication – top <- -> bottom
- Leadership support – ‘walk the talk’
- Reports adverse events and ‘near misses’

Trust-Report-Improve Cycle



Number Events Reported 12 Months

Question Response	Last Period *n*	Last Period %	This Period *n*	This Period %
Number of events reported 12 months				
No event reports			456	56
1 to 2 events			226	28
3 to 5 events			86	11
6 to 10 events			19	2
11 to 20 events			17	2
21 events or more			8	1
Total			812	



Future Directions

- Safety huddles on all units
- Management training on just culture principles
- Recognition for staff who report safety events
- Process for feedback to reporters
- Departmental RCAs to involve more personnel
- Structured performance improvement initiatives
- Leadership walk rounds

ATTACHMENT #3

COOK COUNTY HEALTH & HOSPITALS SYSTEM

CCHHS Board of Directors
Quality and Patient Safety Committee
Quality Plan 2016 Overview

16 August 2016

Krishna Das, MD, Chief Quality Officer

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Goals of a Quality Program

- To continually improve quality processes and outcomes and to comply with law and regulations guiding quality data submission
- To improve patient safety and to comply with laws regarding safety event evaluation and reporting
- To assure successful accreditation and certification
- To create value for the organization
- 'The primary function of a quality department is to decrease variation through the identification and reduction of defects'*

*IHI/NAHQ Quality Structures and Functions at Half the Expense 2013

Regulatory Standards

- CMS 42 CFR 482.21
  - The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program
- Joint Commission LD.01.03.01 and LD.04.04.01
  - The governing body is ultimately accountable for the safety and quality of care, treatment and services
  - Leaders establish priorities for performance improvement

Organization of the Quality Program

Functions

- Patient safety
- Patient experience
- Patient complaints and grievances
- Performance improvement
- Data submission/ data integrity
- Accreditation/policies

Facilities

- Hospitals
  - Stroger
  - Provident
- Ambulatory
  - Primary care
  - Subspecialty
- CCDPH
- Correctional Health
- CountyCare

Ensuring Accountability

- Local leaders report on local performance and lead improvement efforts
- Existing committee structures are used for reporting data and provide governance
- Support leaders with quality data specific to their areas of authority
- Support leaders with guidance on performance improvement methods

Improve Culture of Safety

- Continue to educate staff throughout system on approach to analysis of safety events
- Encourage and reward reporting
- Continue and expand safety briefings
- Engage additional staff in event analysis and demonstrate just-culture concepts
- Process improvement efforts are shared with staff
- Leadership visibility in patient safety efforts

Requirements for Quality Indicators

- Each quality indicator is related to improved health outcomes
- The scope of data collection is appropriate to the indicator
- The source and method of data collection is specified in advance
- Audits of data collection are performed
- Indicators are compared to appropriate benchmarks
- Performance improvement projects reflect high risk, high volume or problem prone areas or activities.

Dashboard Categories

- Key performance indicators, inpatient services
- Key performance indicators, ambulatory services
- Indicators reported to CMS and The Joint Commission
- Nursing quality measures and NDNQI (National Database of Nursing Quality Indicators) data
- Case management and utilization management data
- Patient experience and patient complaints and grievances
- Medical staff committee indicators
- Reporting group dashboards – service line specific dashboards to support collaboration in performance improvement

Key Performance Indicators

Hospital Indicator[1]	Baseline Q3 2015	Target	50th %ile[2]	90th %ile	Reporting Interval
Operating Room: OR on-time starts (%)	47	80	64	88	Quarterly
Operating Room: OR room turnaround time (minutes)	47 min	35 min	29	23	Quarterly
Core Measure: VTE Prophylaxis General Care	89	99	88	99	Quarterly
Prevention: Influenza Vaccination	75	90	93	100	Quarterly
Patient Satisfaction: Recommend the Hospital	69	84.7	72.4	84.7	Quarterly
Patient Satisfaction: Communication with Nurses is 'good'	69	85.7	79.5	85.7	Quarterly
Fall rate/ falls with injury	0.6	25% reduction	-	-	Quarterly
Hospital Acquired Pressure Ulcers	0.6	25% reduction	-	-	Quarterly

Reports to Hospital Quality Committee

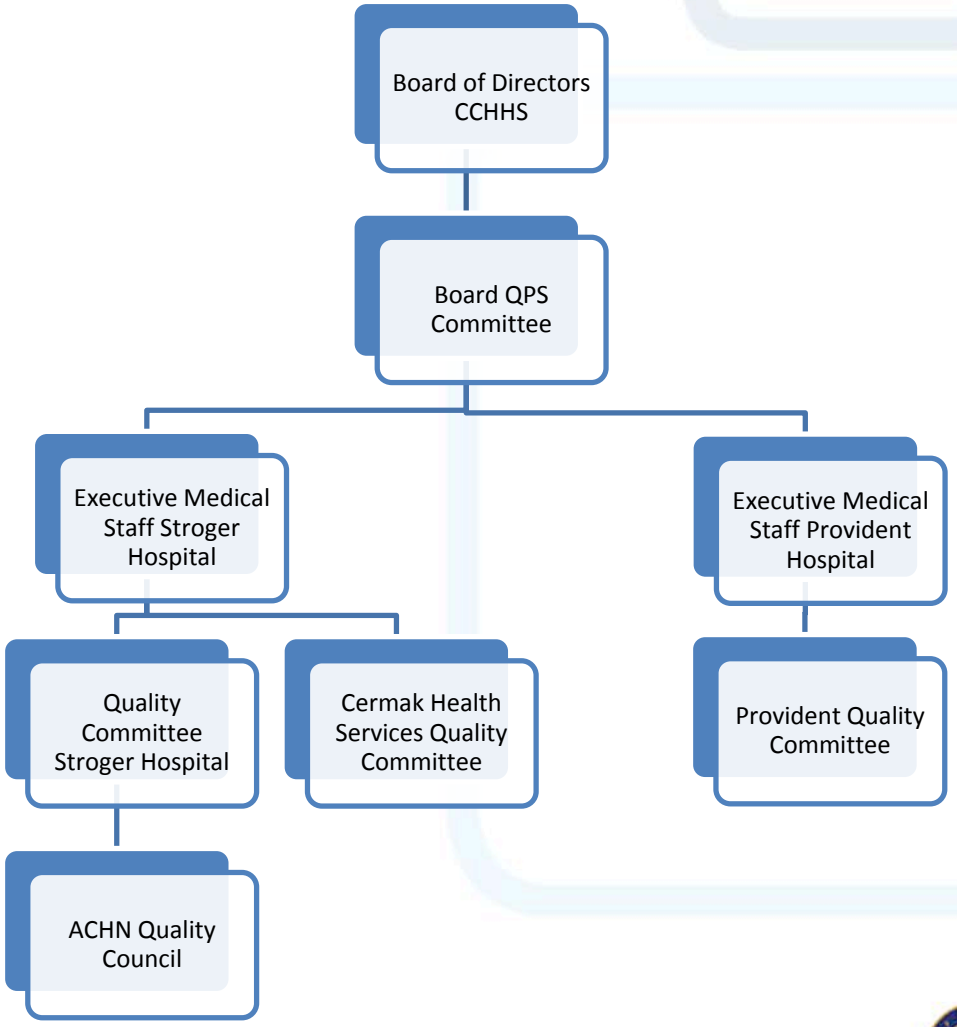
Reporting Group	Departments or Divisions	Committees or Workgroups	Joint Commission Chapter
Perioperative	Surgery, Anesthesia, Ob-Gyne	OR Committee, NSQIP+	NPSG*
Medication Management	Pharmacy	Drug & Formulary, Medication Safety,	Medication Mgmt and NPSG
Environment of Care	Environmental, Police, B&G, CE	Environment of Care	EOC, Life Safety, Emergency Mgmt
Infection Control	Infection Control, OR/SPD, Nursing	Infection Control	Infection Control
Critical Care/ Emergency Response	Critical Care (various), Palliative Care	Critical Care, Resuscitation, Bioethics	Provision of Care
General Med-Surg	Family Medicine, Medicine, Surgery	Stroke, Diabetes, Immunization, NSQIP	Provision of Care
Emergency Services	EM, Trauma/Burn, Nursing	Capacity Management	Provision of Care
Women and Children	Pediatrics, Ob/Gyne		Provision of Care
Behavioral Health	Psychiatry, Nursing	Bioethics	Provision of Care, Pt Rights
Diagnostic Testing	Pathology	Surgical Function Review, IT	Performance Improvement
Radiology/Radiation Safety	Radiology		NPSG
Nursing Services	Nursing	Nursing Quality	Nursing, Provision of Care
Hospital Information Management (HIM)	HIM	HIM, IT	Record of Care and Information Mgmt
Patient Experience of Care	All	Patient Experience Council	Patient Rights
Case Management and Utilization Management	Case Management	Utilization Management	Provision of care
Graduate Medical Education	GME	GMEC	

Structure of Quality Committee

Members of Quality Committee

President, Executive Medical Staff
Executive Medical Director
Medical Department Chairs
Executive Director of Nursing
Chief Quality Officer
COO Hospital Based Services
COO Ambulatory Services
Director of Quality, Ambulatory Services
Associate Executive for Nursing (Stroger Hospital)
Director of Health Information (System)
Director of Patient Experience (System)
Director of Pharmacy (System)
Director of Infection Control (System)
Director of Supply Chain

Quality Reporting



CCHHS John H. Stroger Jr. Hospital Quality Assessment and Performance Improvement Plan

2016

John H. Stroger, Jr. Hospital Quality Plan
Outline

I. Introduction and Purpose

II. Background and Scope

III. Governance and Leadership
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- b. Role of the Executive Medical Staff
- c. Role of the Hospitals Quality Committees
- d. Role of the Quality Department and the Chief Quality Officer

IV. Quality Metrics
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- c. Transparency
- d. CMS Required Metrics
- e. Medical Staff Committees
  - (a) Blood Bank Committee
  - (b) Cancer Committee
  - (c) Critical Care and Resuscitation Committees
  - (d) Drug and Formulary and Drug Use Evaluation Committees
  - (e) Environment of Care Committee
  - (f) Infection Control Committee
  - (g) Operating Room Committee
  - (h) Surgical Function Review Committee
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- h. Performance Targets

V. Performance Improvement

VI. Patient Safety; Transparency
- a. Culture of Safety
- b. Adverse and Sentinel Events
- c. Event Awareness and Notification
- d. Evaluation of Adverse and Sentinel Events
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- f. Proactive Risk Assessments

VII. Patient Experience and Patient Relations

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IX. APPENDICES

a. Appendix A: CMS Regulation for Quality Plan
b. Appendix B: Joint Commission Leadership Standards
c. Appendix C: Joint Commission Performance Improvement Standards
d. Appendix D: Quality Reporting Structure
e. Appendix E: Hospital Wide Quality Improvement and Patient Safety Committee
f. Appendix F: Recognition and Reporting of Adverse Events
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John H. Stroger, Jr. Hospital of CCHHS
Quality Assessment and Performance Improvement Plan 2015

I. **Introduction and Purpose:** The Mission of the Cook County Health and Hospitals System (CCHHS) is *to deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public; and advocate for policies which promote and protect the physical, mental and social well-being of the people of Cook County.*

To support this mission, each entity in the System develops a Quality Assessment and Performance Improvement Plan to specify its approach to quality improvement and to specify key indicators for performance improvement, and to assure approval of the plan by the leaders of the organization including the Board of Directors and the Executive Medical Staff. The purpose of this document is to set forth the Quality Assessment and Performance Improvement Plan for John H. Stroger, Jr. ('Stroger Hospital') for CY 2016.

'Stroger Hospital' includes the hospital itself, the hospital based clinics and all the clinics included in the Ambulatory and Community Health Network which are registered under the CCN number for Stroger Hospital.

II. **Background and Scope:** A comprehensive quality improvement plan supports the Cook County Health and Hospitals System and John H. Stroger, Jr. Hospital's goals to provide excellent, high quality patient care and outlines the mechanisms to achieve this goal. The plan fulfills requirement for the Conditions of Participation of the Centers for Medicare & Medicaid Services (CMS) (**APPENDIX A)** and The Joint Commission (**APPENDIX B and APPENDIX C)**, the accrediting organization for the Hospital and the Health System. The plan is to be approved by the governing body of CCHHS which is the Board of Directors, upon the recommendation of its committee on Quality and Patient Safety, and upon approval by the Executive Medical Staff of Stroger Hospital and System Leadership. By approving the plan, the Board of Directors, the System Leadership and the Executive Medical Staff are:

a. Overseeing the quality and patient safety activities within the organization
b. Ensuring that the organization takes a proactive approach to planning for patient safety and quality patient care
c. Ensuring that an integrated safety program exists within the organization
d. Setting priorities for performance improvement, evaluating the performance improvement practices in the organization and ensuring that performance improvement strategies and methodologies are implemented throughout the organization
e. Ensuring data collection and monitoring in diverse areas as specified below
f. Ensuring that the hospital analyzes and compares the data it collects using statistical techniques and that data and other information are used systematically for decision making.

This plan reflects institutional quality priorities for FY 2016 for Stroger Hospital. The written plan allows the Executive Medical Staff and the Board of Directors to ensure that the

program reflects the complexity of the hospital's organization and services and involves all departments and services. The plan enumerates quality indicators and together with the Patient Safety Plan, describes the hospital's process to prevent and reduce medical errors. This plan provides direction for a hospital-wide, data driven quality assessment and performance improvement program.

The structure of the Quality Assessment and Performance Improvement Plan is derived from the Triple Aim enunciated by the national quality strategy within the Affordable Care Act. This directs health care providers to improve the experience of care for individuals, to assess and improve the care of populations and to lower per capita costs in health care. In addition, as outlined by the Institute of Medicine Report, '*To Err is Human*', quality improvement efforts in health care should ensure that patient care is safe, timely, effective, efficient, equitable and patient centered. Stroger Hospital is committed to addressing these dimensions of quality within the Quality Assessment and Performance Improvement plan.

III. **Governance and Leadership:** Overall direction for the quality plan for Stroger Hospital is provided by its governing body, the Board of Directors; by the medical staff through its elected representatives, the Executive Medical Staff Committee; and by the leadership of CCHHS. The plan is to be approved by the Executive Medical Staff Committee of the Hospital; and by the Quality and Patient Safety Committee and the Board of Directors of the CCHHS. Quality and patient safety metrics are reported regularly as part of a quality and safety dashboard to the Executive Medical Staff and the Board of Directors as described in **APPENDIX D.**

Oversight for the implementation of the Quality Plan is provided by the Department of Quality and Patient Safety led by the Chief Quality Officer and executed in collaboration with departmental and medical staff quality committees, hospital and system leadership and the System Departments of Risk Management, Legal, and Compliance.

The Hospital Quality Improvement and Patient Safety Committee provides oversight of the Quality Program as well as the Patient Safety Program. The composition and leadership of this committee is presented in **APPENDIX E**. This committee meets monthly and reviews all quality metrics, departmental and committee quality data, patient safety data and prioritizes performance improvement projects. The committee chair or designee reports the activities of the committee to the Executive Medical Staff on a monthly basis. Quality data are reported to the CCHHS Board of Directors on a monthly basis through its committee on Quality and Patient Safety.

IV. **Quality Metrics:** Quality measures are collected and reported to monitor quality of care; to inform performance improvement activities; to report to federal, state and county governments; for regulatory purposes and to support reimbursement and pay for performance initiatives. This section describes the metrics, the methods of abstraction and performance targets for FY 2016. The Board of Directors along with System Leadership and the Executive Medical Staff set the priorities for data collection as well as the frequency of

data collection. The Board of Directors assures adequate resources to accomplish data acquisition and analyses required for the quality program.

a. Dashboards are created within the following categories.
   i. Key performance indicators, inpatient services (**APPENDIX G**) *:* The Hospital quality priorities are to improve access to care, demonstrate excellence in the delivery of care and to improve patient satisfaction. The baseline measurement is Q3 of 2015 and achievement will be assessed in Q3 of 2016. Data on progress toward the targets will be reported monthly to the Board of Directors.
   ii. Key performance indicators, ambulatory services: for further details please see the ACHN Quality Plan
   iii. Indicators reported to CMS and The Joint Commission (**APPENDIX H and I**)
   iv. Nursing quality measures and NDNQI (National Database of Nursing Quality Indicators) data
   v. Case management and utilization management data
   vi. Patient experience and patient complaints and grievances
   vii. Medical staff committee indicators
   viii. Reporting group dashboards – service line specific dashboards which include several of the items from i. to vii. above and which support collaboration in performance improvement (**APPENDIX J**)

b. Requirements for Quality Indicators:
   i. Each quality indicator is related to improved health outcomes
   ii. The scope of data collection is appropriate to the indicator
   iii. The source and method of data collection is specified in advance
   iv. Oversight (audits) of data collection methods are performed
   v. Indicators are compared to appropriate benchmarks whenever these are available
   vi. Unit by unit comparisons are made whenever appropriate
   vii. Performance improvement projects are selected from areas where quality indicators reflect areas needing improvement
   viii. Performance improvement projects reflect high risk, high volume or problem prone areas or activities.

c. *Transparency:* CCHHS is committed to transparency in the abstraction and reporting of quality metrics. These metrics, together with the performance targets set by the leadership, are to be disseminated widely among leadership and staff and will be available for viewing internally on the CCHHS website.

d. *CMS Required Metrics:* Under the inpatient quality reporting (IQR) program of CMS the metrics are abstracted and reported on a quarterly basis to CMS. A subset of these measures is reported to the Joint Commission (see **APPENDIX H**). These measures are reported publicly on Hospital Compare.
   i. Process Measures: Evidence based process measures reflect good clinical practice and high levels of achievement in these areas correlate with good patient outcomes. These processes include stroke care, preventive

interventions in all patients to reduce the incidence of thromboembolism in the hospital, to administer influenza vaccination and to properly care for surgical patients (**APPENDIX H**). The hospital's performance in these areas is used to determine the priorities for performance improvement projects.

ii. Outcome Measures: Mortality and Readmissions: CMS uses administrative data to calculate overall mortality, readmission rates to the hospital and rates of hospital acquired conditions.

iii. Outcome Measures: Hospital Acquired Conditions: Hospital acquired infections represent a major, and preventable, source of morbidity in the hospital (**APPENDIX I**). Hospital acquired complications (Patient Safety Indicators, or PSIs) are abstracted from hospital claims and reported on Hospital Compare.

iv. Efficiency Measures: Emergency Department(ED) Throughput: Wait times in the ED are monitored.

e. *Medical Departments and Medical Staff Committees*: The medical staffs are responsible to the Executive Medical Staff Committee and the Quality Committee for maintaining a consistently high level of patient care. Each department or committee has identified quality priorities which support institutional goals and which are tracked on a regular basis and inform performance improvement activities for the department or committee. These are reported to the Quality Committee via the reporting groups listed in **APPENDIX J**.

1. Blood Bank Committee: collects data on the appropriateness of the use of blood and blood products and on all reported and confirmed transfusion reactions.
2. Cancer Committee: reports results of cancer prevention, and psychosocial assessment of cancer patients.
3. Critical Care and Resuscitation Committees: the Critical Care committee collects data on diverse indicators related to intensive care. FY 2016 priorities for this committee include monitoring restraint prevalence and process, and improving the reporting of resuscitation results.
4. Drug and Formulary and Drug Use Evaluation Committees: In FY 2016 this committee will review appropriate utilization of medical therapy.
5. Environment of Care committee: Evaluates environmental and life safety hazards, monitors the response to product safety and device alerts and recalls, and provides oversight of the Emergency Response Plan.
6. Infection Control Committee: Priorities for this committee for FY 2016 include reducing the risks of catheter associated urinary tract infections and monitoring and improving compliance with hand hygiene.
7. Operating Room Committee: works collaboratively with the Departments of Surgery, Anesthesia and Nursing to enforce use of surgical checklists and time outs and improve OR throughput.
8. Surgical Function Review Committee: a high priority for FY 2016 is to improve the timeliness of reporting of serious pathology results.

f. *Data Abstraction:* CCHHS uses computer supported data abstraction through the electronic health record (EHR) for the majority of reported measures. Cases are sampled automatically and are linked via the EHR for manual review. Numerator data are assessed by the abstractor and compliance is measured as a percentage. Data is abstracted monthly for all process measures. Data submission is through a third party. Data for outcome measures may be abstracted by hospital abstractors (ED data), or reported to CMS via standard channels. EHR dashboard reports are sent directly to area manager or department chairs for analysis and feedback and are reported in summary form to the Hospital Quality Improvement and Patient Safety meetings. Audits are conducted by managers or chairs/designees with input and oversight from the Quality department.

g. *Data Analysis:* The source and specific numerator and denominator of each measure is listed whenever possible. Data is compared to external benchmarks whenever these are available. Data may be displayed using run charts which show the evolution of performance over time and can be correlated with performance improvement initiatives. The goal is to achieve high reliability in quality measures.

h. *Performance Targets:* These are determined by the type of data (process or outcome) and by indicator. A subset of process measures have been selected for the Hospital's and System's quality priorities for FY 2016 (see below). Performance targets are set at a higher threshold for these metrics, to the top decile (> 90%ile). One set of outcome measures, OR throughput, has also been selected as a quality priority (see below). For all other measures, the achievement target for FY 2016 is above median performance (> 50th %ile).

V. **Performance Improvement:** Priorities for performance improvement are established by the organizations leadership, which includes the Quality Committee, Executive Medical Staff, System Leadership and the Board of Directors. High-risk, high-volume or problem prone areas are prioritized for performance improvement projects after consideration of the incidence, prevalence and severity of problems in these areas and whether these problems are known to affect health outcomes, patient safety and quality of care. Performance improvement projects are proportional to the scope and complexity of the hospital's services. Data analysis identifies areas needing improvement, and guides the institution of a performance improvement program. Distinct improvement activities are performed throughout the hospital, proportional to the scope and complexity of the care provided in each area.

The hospital's approach to performance improvement projects is in a transitional phase from P-D-C-A to a Lean/Six Sigma Approach. This choice reflects the emphasis on value in health care operations and the alignment of Lean concepts with value and the reduction of waste. This approach accurately reflects the multidisciplinary nature of health care and the processes under study. The Lean approach also supports the possibility of rapid cycle performance improvement which may be used in selected cases, particularly in unit based improvement programs.

Performance improvement projects will address variation by designing high-reliability interventions which are known to create sustained changes. This includes system redesign, forcing functions, checks and redundancies and consideration of human factors. High

reliability organizations are characterized by sensitivity to operations, reluctance to simplify, a preoccupation with failure, deference to expertise and resilience.

Monitoring of performance improvement activities will be provided by the hospital Quality Committee. Interventions will be evaluated for success and sustained improvement. Staff in the Department of Quality and Patient Safety will process data required for performance improvement projects and provide facilitation for these projects as required.

VI. **Patient Safety Program:** The Stroger Hospital Quality Improvement and Patient Safety Committee ('Quality Committee') is the multidisciplinary committee (**APPENDIX E**) which provides guidance for the Hospital's patient safety program under the leadership of the Patient Safety Officer. More detail can be found in the hospital's Patient Safety Plan.

a. *Culture of Safety:* Stroger Hospital recognizes the importance of a strong safety culture to support and improve quality and safety within the organization. Safety culture is measured using a validated, benchmarked survey.

i. *Assessment:* An anonymous, on-line safety culture survey is administered at all CCHHS affiliates and is analyzed using national benchmark data.

ii. *Staff Education:* Staff education and training is provided to convey expectations for patient safety to all staff, including the expectation to report patient safety events. This includes training sessions during new staff orientation, a dedicated module during annual training and training of hospital managers during the Leadership Development Program. In addition numerous trainings are held within clinical departments and for Graduate Medical Education programs.

iii. *Interventions*: Several interventions to enhance the culture of safety are ongoing or planned, including safety Briefings, Safety Huddles, and leadership Walk Rounds.

b. *Adverse and Sentinel Events:* The definition, reporting and evaluation of adverse events are dictated by regulation and hospital policy. The initial reporting process is outlined in **APPENDIX F**. Significant events are evaluated by departmental and/or hospital wide oversight committees. Root cause analyses are performed for all significant safety events as defined by hospital policy and the Joint Commission, and for serious adverse events as defined by the National Quality Foundation. The results of the evaluation of such events are reported to the hospital leadership and the Executive Medical Staff.

c. *Event Awareness and Notification:* Adverse events may be reported using a variety of systems.

i. Electronic event reporting system: The UHC Safety Intelligence © electronic reporting system is used and known locally as eMERS. This system also functions as a PSO (patient safety organization).

ii. Phone calls: confidential phone reports may be made by care providers to the Quality Improvement/Patient Safety department (phone line: 4-SAFE or 4-7233), to Risk Management, or to the Executive Medical Director.

iii. Departmental reports: Medical and Nursing departments have internal review processes to assess the quality of care provided by members of the respective department. This includes oversight activities, case conferences, mortality and morbidity reviews, reviews performed for OPPE or FPPE (ongoing or focused professional practice evaluation), or evaluations conducted by the Medical Staff Peer Review Committee.

iv. Referrals from outside agencies: Although rare, events may be identified during review by IDPH (Illinois Department of Public Health), CMS (Centers for Medicare & Medicaid Services) or the The Joint Commission.

All of the above events, regardless of the method of identification, are reported internally as described in **APPENDIX F** and evaluated as described below.

d. *Evaluation of Adverse and Sentinel Events:* The management of adverse and sentinel events is described in hospital policy. Serious events are evaluated thoroughly with a goal to understand the underlying causes or contributing factors and to mitigate the risk of future events. Other areas of the hospital which may carry similar risks are identified. A structured, interdisciplinary RCAs (root cause analyses) is performed.

e. *Event Resolution and Action Plans:* The RCAs identify process changes to reduce the risk of recurrence of safety events. Action plans identify specific interventions, the person(s) responsible for the intervention, and define measures of success. Managers in relevant areas monitor and report on the implementation and the results of the action plans. Oversight of these plans is provided by the Oversight committee and the Hospital Quality and Patient Safety Committee.

f. *Proactive Risk Assessments*: Stroger Hospital conducts proactive risk assessments in identified high risk areas. One high risk process is selected annually for an in-depth analysis using failure modes and effects analysis (FMEA). This multidisciplinary process utilizes process mapping, identifies potential failure modes and examines the impact of these failure modes on patient care. A risk scoring system is used for identifying, evaluating and prioritizing improvement opportunities. *The FMEA prioritized for 2016 is an assessment of patients who deteriorate clinically while under care and require rescue; and the consequences of failure to rescue.*

VII. **Patient Experience and Patient Relations:** Patient perceptions of the safety and quality of care are vitally important to the development of a responsive, patient centered organization. Stroger Hospital welcomes feedback, comments and complaints from patients and recognizes that patients and their families have the right to have complaints and grievances reviewed by the hospital. An established complaint resolution process implemented by the Office of Patient Relations receives, prioritizes and responds to all complaints from patients. Serious consideration is given to every complaint, and hospital policy is established regarding timeliness of resolution. These processes are designed not only to enhance patient satisfaction but to also identify conditions which may impact on patient safety.

Structured surveys (HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems) are administered to patients who have received care in the organization by an independent entity and the results are reported to local managers, hospital leadership and to CMS. This type of feedback from patients is used to restructure processes to support patient safety, communication and patient education.

VIII. **Confidentiality**: All information, data, reports, minutes or memoranda relating to the implementation of this Quality Assessment and Performance Improvement Plan are solely for use in the course of internal quality control for the purpose of reducing morbidity and mortality and improving patient care. As such, they are strictly confidential under the Illinois Medical Studies and Hospital Licensing Act. The confidentiality of patient specific data will be protected in observance of HIPAA regulations and aggregated, de-identified data will be used whenever possible for quality data reporting.

APPENDIX A
CMS (Centers for Medicare and Medicaid Services) Regulations Guiding Quality Plans

Regulation (CFR 482.21 sections A-0263 - A-0267):

The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services, involves all hospital departments and services (including those services furnished under contract or arrangement), and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

(a) Standard: Program Scope

(1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and identify and reduce medical errors.
(2) The hospital must measure, analyze and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations.

(b) Standard: Program Data

(1) The program must incorporate quality indicator data including patient care data and other relevant data, eg information submitted to or received from the hospital's Quality Improvement Organization.
(2) The hospital must use the data collected to (i) monitor the effectiveness and safety of services and quality of care and (ii) identify opportunities for improvement and changes that will lead to improvement.
(3) The frequency and detail of data collection must be specified by the hospital's governing body.

(c) Standard: Program Activities

(1) The hospital must set priorities for its performance improvement activities that: (i) focus on high-risk, high-volume, or problem-prone areas; (ii) consider the incidence, prevalence, and severity of problems in those areas and (iii) affect health outcomes, patient safety and quality of care.
(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.
(3) The hospital must take actions aimed at performance improvement and after implementing those actions the hospital must measure its success and track performance to ensure that improvements are sustained.

(d) Standard: Performance Improvement Projects

As part of its quality assessment and performance improvement program the hospital must conduct performance improvement projects.

(1) The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations.
(2) A hospital may.. develop and implement an information technology system explicitly designed to improve patient safety and quality of care.
(3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects and the measurable progress achieved on these projects.

(e) Standard: Executive Responsibilities

The hospital's governing body, medical staff, and administrative officials are responsible and accountable for ensuring the following:

(1) That an ongoing program for quality improvement, and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
(2) That the hospital-wide quality assessment and quality improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated.
(3) That clear expectations for safety are established.
(4) That adequate resources are allocated for measuring, assessing, improving and sustaining the hospital performance and reducing risk to patients.
(5) The determination of … projects is conducted annually

APPENDIX B:
Joint Commission Leadership Standards

LD.01.03.01
The governing body is ultimately accountable for the safety and quality of care, treatment and services. The governing body defines in writing its responsibilities

LD.02.03.01
The governing body, senior manager and leaders of the organized medical staff regularly communicate with each other on issues of safety and quality. Leaders discuss issues that affect the hospital and the population it serves, including performance improvement activities, reported safety and quality issues, proposed solutions and their impact on resources, reports on key quality measures and safety indicators, safety and quality issues specific to the population served.

LD.03.01.01
Leaders create and maintain a culture of safety throughout the hospital. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools and prioritize and implement changes identified by the evaluation.

LD.03.02.01
The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

LD.03.05.01
Leaders implement changes in existing processes to improve the performance of the hospital. Structures for managing change and performance improvement exist. The hospital has a systematic approach to change and performance improvement. Leaders provide resources required for performance improvement and change management.

LD.04.04.01
Leaders establish priorities for performance improvement; set priorities for performance improvement activities and patient health outcomes, and give priority to high-volume, high-risk or problem prone processes for performance improvement activities.

LD.04.04.03
New or modified services and processes are designed incorporating multiple factors (i.e. patient/staff needs, results of quality activities, information about patient risks, and sentinel event information)

LD.04.04.05
The hospital has an organization-wide, integrated patient safety program within its performance improvement activities. The leaders implement a hospital-wide patient safety program. One or more qualified individuals or an interdisciplinary group manages the safety program. The scope of the safety program includes the full range of safety issues, from potential or no-harm errors to hazardous conditions and sentinel events. All departments, programs and services within the hospital participate in the safety program.

APPENDIX C:
Joint Commission Performance Improvement Standards

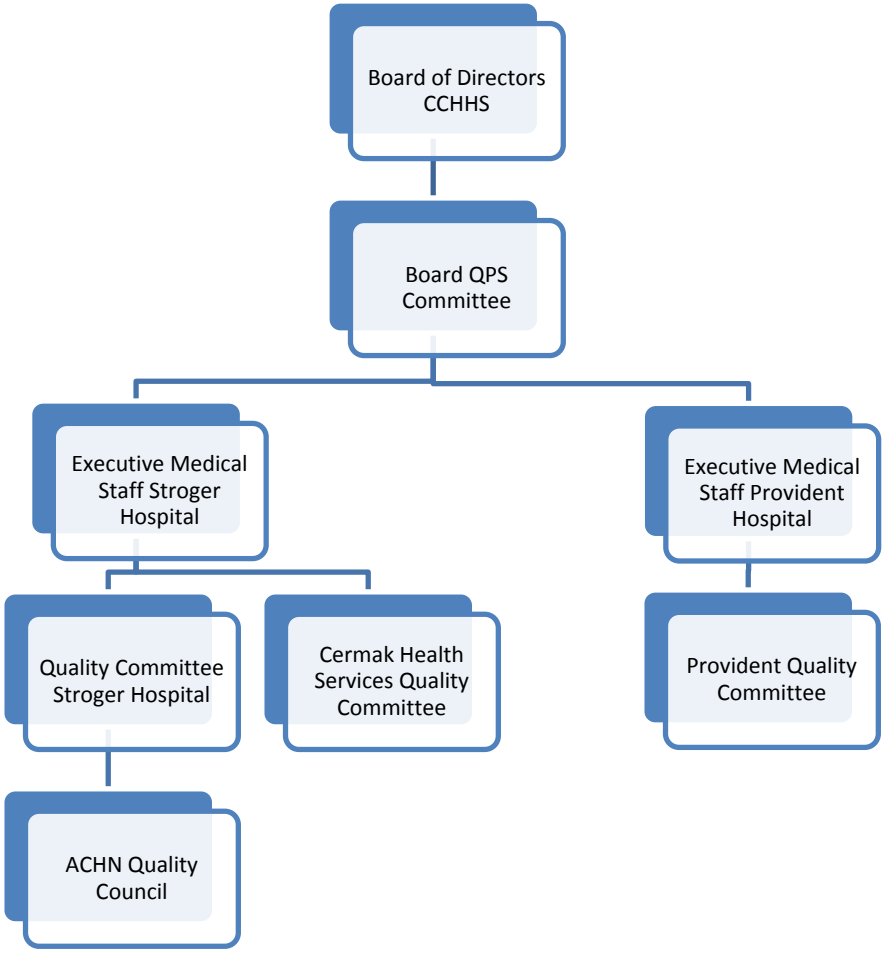
PI.01.01.01, EP 1-8, 11, 12, 14-16, 30, 38
The hospital collects data to monitor its performance. Leaders set priorities for data collection. The leaders identify the frequency for data collection. The hospital collects data on

- the performance improvement priorities identified by leaders
- operative and other procedures that place the patient at risk of disability or death
- all significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
- adverse events related to using moderate or deep sedation
- use of blood and blood components
- all reported and confirmed transfusion reactions
- results of resuscitation
- behavior management and treatment
- significant medication errors
- significant adverse drug reactions
- patient perception of the safety and quality of care, treatment, and services
- effectiveness of fall reduction activities
- effectiveness of response to change or deterioration in a patient's condition

PI.02.01.01, EP 1-8
The hospital compiles and analyzes data. The hospital compiles data in usable formats, identifies the frequency for data analysis, uses statistical tools and techniques to analyze and display the data, analyzes and compares internal data over time to identify levels of performance, patterns, trends and variations, and compares data with external sources, when available.

PI.03.01.01, EP 1-4
The hospital improves performance on an ongoing basis. Leaders prioritize the identified improvement opportunities. The hospital takes action on improvement priorities. The hospital evaluates actions to confirm that they resulted in improvements.

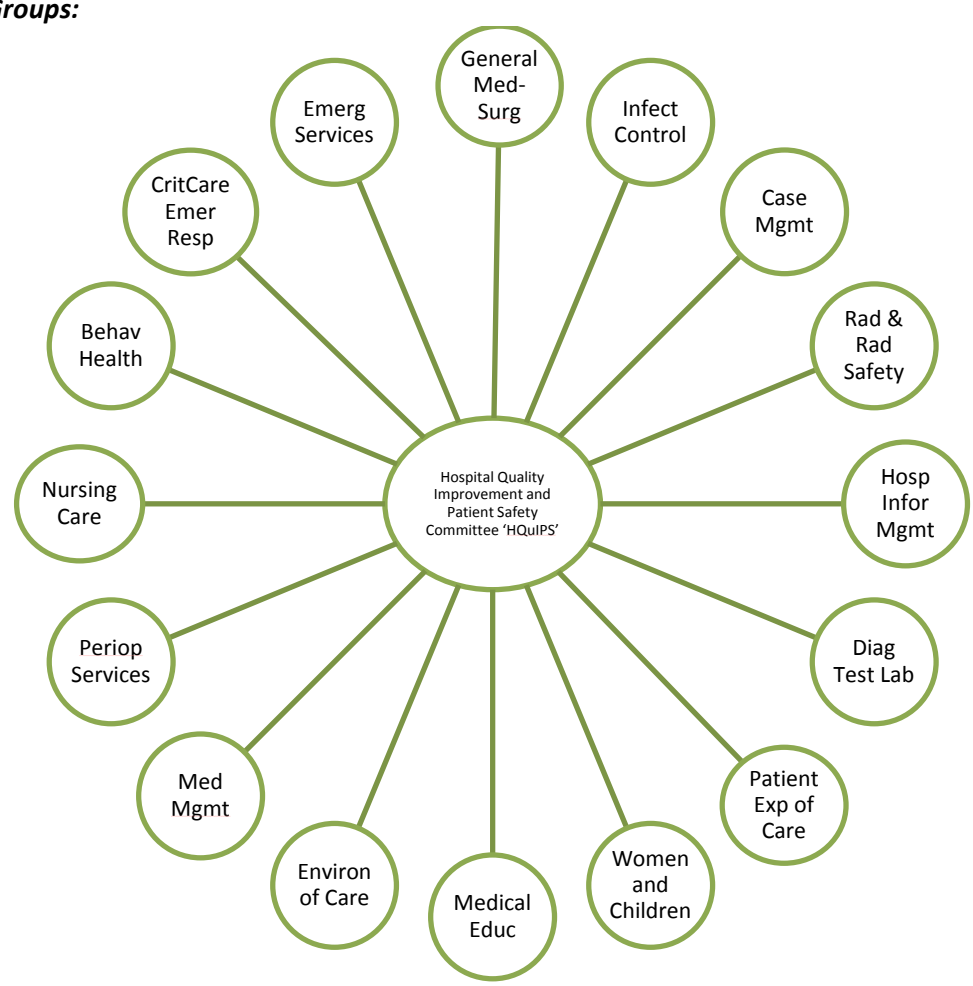
APPENDIX D:
CCHHS Quality Reporting Overview



*Reports to the Board may be provided by the Chief Operating Officer for Hospital Based Services or by the Chief Quality Officer or the Executive Medical Director

APPENDIX E:
Hospital Wide Quality Improvement and Patient Safety Committee Description

Reporting Groups:



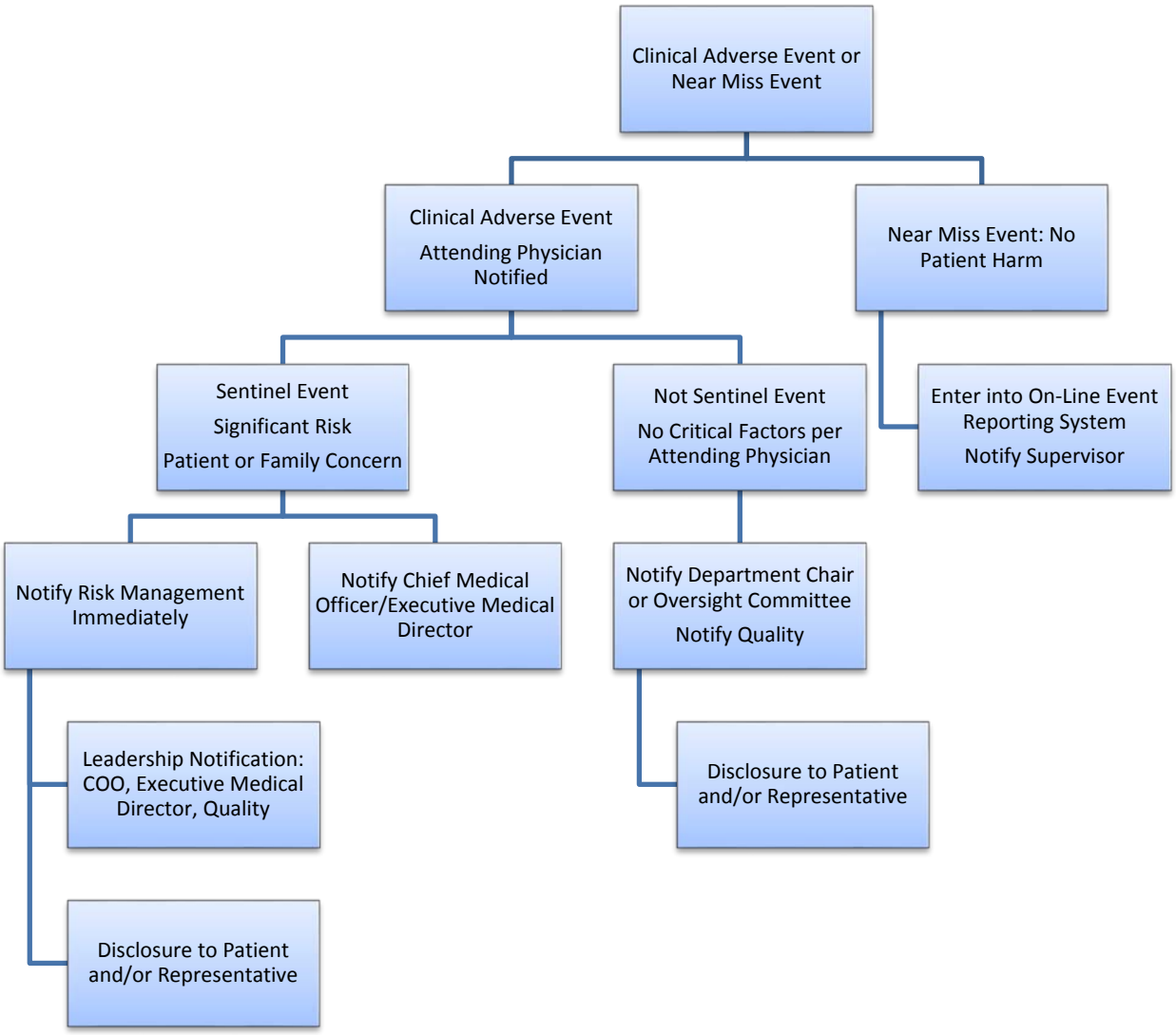
Committee Membership:

President, Executive Medical Staff
Executive Medical Director (System)
Medical Department Chairs
Executive Director of Nursing
Chief Quality Officer (System)
COO Hospital Based Services
COO Ambulatory Services
Director of Quality, Ambulatory Services
Associate Executive for Nursing (Stroger Hospital)
Director of Health Information (System)
Director of Patient Experience (System)
Director of Pharmacy (System)
Director of Infection Control (System)
Director of Supply Chain

Ex Officio

Chair, Quality and Patient Safety Subcommittee, CCHHS Board of Directors
Chief Financial Officer (System)
CMIO (System)
Quality Staff
Clinical Informatics Director

APPENDIX F:
Recognition and Reporting of Adverse Events



APPENDIX G
Key Performance Indicators – Inpatient Services

Hospital Indicator[1]	Baseline Q3 2015	Target	50th %ile[2]	90th %ile	Reporting Interval
Operating Room: OR on-time starts (%)	47	80	64	88	Quarterly
Operating Room: OR room turnaround time (minutes)	47 min	35 min	29	23	Quarterly
Core Measure: VTE Prophylaxis General Care	89	99	88	99	Quarterly
Prevention: Influenza Vaccination	75	90	93	100	Quarterly
Patient Satisfaction: Recommend the Hospital	69	84.7	72.4	84.7	Quarterly
Patient Satisfaction: Communication with Nurses is 'good'	69	85.7	79.5	85.7	Quarterly
Fall rate/ falls with injury	0.6	25% reduction	-	-	Quarterly
Hospital Acquired Pressure Ulcers	0.6	25% reduction	-	-	Quarterly

APPENDIX H
CMS Inpatient Quality Reporting (IQR) and Joint Commission Indicators – 2015

Measure	Data Type*
CMS IQR	
STK-4 Stroke- Thrombolytic Therapy	Chart Abstraction
VTE-5 Warfarin Discharge Instructions	Chart Abstraction
VTE-6 Hospital Acquired VTE	Chart Abstraction
ED-1 Time from ED Arrival to Admission	Chart Abstraction
ED-2 Time from Decision to Admission	Chart Abstraction
IMM-2 Influenza Vaccination	Chart Abstraction
PC-01 Early Elective Deliveries	Chart Abstraction
SEP Compliance with the Sepsis Bundle	Chart Abstraction
Joint Commission	
STK-4 Stroke- Thrombolytic Therapy	Chart Abstraction
VTE-2 VTE Prophylaxis in the ICU	eCQM
ED 1&2 Time from ED Arrival/Decision to Admission	Chart Abstraction
ED 1&2 Time from ED Arrival/Decision to Admission	eCQM
IMM-2 Influenza Vaccination	Chart Abstraction
PC (All) Perinatal Care	Chart Abstraction

*Method of data abstraction: Chart abstraction requires manual review, eCQM is electronically abstracted

APPENDIX I
Hospital Acquired Conditions – 2015

Condition	Data Source
PSI-90 Hospital and Surgical Complications	
PSI-03 Pressure Ulcers	Claims
PSI-06 Iatrogenic Pneumothorax	Claims
PSI-07 Central Venous Line Infections	Claims
PSI-08 Post-op Hip Fracture	Claims
PSI-12 Post-op Venous Thromboembolism	Claims
PSI-13 Post-op Sepsis	Claims
PSI-14 Post-op Wound Dehiscence	Claims
PSI-15 Accidental Puncture or Laceration	Claims
HAI- Hospital Acquired Infections	
Central Line Associated Blood Stream Infections	NHSN
Surgical Site Infections	NHSN
Catheter Associated Urinary Tract Infections	NHSN
MRSA Bacteremia	NHSN
C Difficile Associated Disease	NHSN
Influenza Vaccination of Healthcare Workers	Local/NHSN

APPENDIX J:
Medical Staff Committees and Departmental Reporting
Reporting Group Descriptions

Reporting Group	Departments or Divisions	Committees or Workgroups	Joint Commission Chapter
Perioperative	Surgery, Anesthesia, Ob-Gyne	OR Committee, NSQIP+	NPSG*
Medication Management	Pharmacy	Drug & Formulary, Medication Safety,	Medication Mgmt and NPSG
Environment of Care	Environmental, Police, B&G, CE	Environment of Care	EOC, Life Safety, Emergency Mgmt
Infection Control	Infection Control, OR/SPD, Nursing	Infection Control	Infection Control
Critical Care/ Emergency Response	Critical Care (various), Palliative Care	Critical Care, Resuscitation, Bioethics	Provision of Care
General Med-Surg	Family Medicine, Medicine, Surgery	Stroke, Cancer, NSQIP	Provision of Care
Emergency Services	EM, Trauma/Burn, Nursing	Capacity Management	Provision of Care
Women and Children	Pediatrics, Ob/Gyne		Provision of Care
Behavioral Health	Psychiatry, Nursing	Bioethics	Provision of Care, Pt Rights
Diagnostic Testing	Pathology	Surgical Function Review, Blood Bank	Performance Improvement
Radiology/Radiation Safety	Radiology		NPSG
Nursing Services	Nursing	Nursing Quality	Nursing, Provision of Care
Hospital Information Management (HIM)	HIM	HIM, IT	Record of Care and Information Mgmt
Patient Experience of Care	All	Patient Experience Council	Patient Rights
Case Management and Utilization Management	Case Management	Utilization Management	Provision of care
Graduate Medical Education (GME)	GME	GMEC	

+NSQIP = National Surgical Quality Improvement Program
*NPSG = National Patient Safety Goals

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ATTACHMENT #4

Date: August 10, 2016

Dear members of the Quality and Patient Safety Committee of the CCHHS Board:

Please be advised that the Executive Medical Staff Committee of John H. Stroger, Jr. Hospital of Cook County used the electronic poll to approve the attached list of medical staff action items for your consideration. This step was necessary because the Committee does not meet during the month of August.

Thank you very much.

Respectfully submitted,

Ozuru O. Ukoha, MD
President, EMS

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

John H. Stroger, Jr. Hospital of Cook County

Medical Staff and Non-Medical Staff Action Items subject to approval by the CCHHS Quality and Patient Safety Committee.

INITIAL APPOINTMENT APPLICATIONS

Initial Physician Appointment Applications

Adams, Carmen, MD Appointment Effective:	OB/GYN August 16, 2016 thru August 15, 2018	Active
Bhat, Gifty, MD Appointment Effective:	Pediatrics August 16, 2016 thru August 15, 2018	Active
Caughlin, Benjamin, MD Appointment Effective:	Surgery/Otolaryngology August 16, 2016 thru August 15, 2018	Consulting
Clary, Tyrisha, MD Appointment Effective:	Correctional Health/Medicine August 16, 2016 thru August 15, 2018	Active
Ezeife, Ijeoma, MD Appointment Effective:	Medicine/Hospital Medicine September 16, 2016 thru September 15, 2018	Active
Haq, Yaser, MD Appointment Effective:	Correctional Health/Psychiatry August 16, 2016 thru August 15, 2018	Active
Miller, Joyce, MD Appointment Effective:	Correctional Health/Psychiatry September 28, 2016 thru September 27, 2018	Active

Initial Non-Physician Appointment Applications

Biancalana-Marsh, Lisa, CNP With Davidovich, Michael, MD Effective:	Medicine/General Medicine August 16, 2016 thru August 15, 2018	Nurse Practitioner
Roman, LaToyia, CNP With Patel, Sanjay, MD Effective:	Medicine/Hospital Medicine August 16, 2016 thru August 15, 2018	Nurse Practitioner
Songkum, Jantanee, CNP With Akintorin, Mopelola Subuola, MD Effective:	Pediatrics/Neonatology August 16, 2016 thru August 15, 2018	Nurse Practitioner

REAPPOINTMENT APPLICATIONS

Department of Anesthesiology:

Paek, Hyang Won, MD Reappointment Effective:	Anesthesiology September 21, 2016 thru September 20, 2018	Active

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APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON AUGUST 16, 2016

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications (continued)

Department of Correctional Health Services:

Howard, Jonathan, MD	Psychiatry	Voluntary
Reappointment Effective:	August 16, 2016 thru August 15, 2018	
McNeal, Jenea, MD	Psychiatry	Active
Reappointment Effective:	November 16, 2016 thru November 15, 2018	

Department of Emergency Medicine:

Smith, Lauren, MD	Emergency Medicine	Active
Reappointment Effective:	September 23, 2016 thru September 22, 2018	

Department of Family Medicine:

Bradley, Juliet, MD	Family Medicine	Active
Reappointment Effective:	November 16, 2016 thru November 15, 2018	

Department of Medicine:

Abrahamian, Frida, MD	Gastroenterology	Voluntary
Reappointment Effective:	September 6, 2016 thru September 5, 2018	
Ahmed, Azzazudin, MD	General Medicine	Active
Reappointment Effective:	July 25, 2016 thru July 24, 2018	
Amblee, Amibka, MD	Endocrinology	Active
Reappointment Effective:	October 16, 2016 thru October 15, 2018	
Atten, Mary Jo, MD	Gastroenterology	Active
Reappointment Effective:	October 17, 2016 thru October 16, 2018	
Block, Joel, MD	Rheumatology	Voluntary
Reappointment Effective:	October 21, 2016 thru October 20, 2018	
Case, John P., MD	Rheumatology	Active
Reappointment Effective:	October 21, 2016 thru October 20, 2018	
Clarke, Peter, MD	General Medicine	Active
Reappointment Effective:	October 21, 2016 thru October 20, 2018	
Doukky, Rami, MD	Adult Cardiology	Active
Reappointment Effective:	October 16, 2016 thru October 15, 2018	
Gandhi, Seema R., MD	Gastroenterology	Active
Reappointment Effective:	October 28, 2018 thru October 27, 2018	
Golzar, Yasmeen, MD	Adult Cardiology	Active
Reappointment Effective:	October 16, 2016 thru October 15, 2018	

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APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON AUGUST 16, 2016

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications

Department of Medicine (continued):

Gomez-Valencia, Javier, MD	Adult Cardiology	Active
Reappointment Effective:	October 16, 2016 thru October 15, 2018	
Hwang, Jessica, MD	Endocrinology	Active
Reappointment Effective:	October 28, 2016 thru October 27, 2018	
Lee, Anna Mae, MD	General Medicine	Voluntary
Reappointment Effective:	September 28, 2016 thru September 27, 2018	
Mathew, Suja, MD	General Medicine	Active
Reappointment Effective:	October 17, 2016 thru October 16, 2018	
Mohiuddin, Reshma, MD	General Medicine	Active
Reappointment Effective:	October 16, 2016 thru October 15, 2018	
Pierko, Krzysztof, MD	General Medicine	Active
Reappointment Effective:	October 16, 2016 thru October 15, 2018	
Raba, John, MD	General Medicine	Voluntary
Reappointment Effective:	October 28, 2016 thru October 27, 2018	
Rohr, Louis, MD	General Medicine	Active
Reappointment Effective:	October 17, 2016 thru October 16, 2018	
Sonenthal, Kathy, MD	Pulmonary & Critical Care	Voluntary
Reappointment Effective:	October 17, 2016 thru October 16, 2018	
Vargas,Sergio, MD	Hospital Medicine	Active
Reappointment Effective:	September 28, 2016 thru September 27, 2018	
Williams, Brett, MD	Infectious Disease	Voluntary
Reappointment Effective:	October 28, 2016 thru October 27, 2018	

Department of Obstetrics and Gynecology:

Gerber, Susan, MD	OB/GYN	Voluntary
Reappointment Effective:	September 23, 2016 thru September 22, 2018	

Department of Pediatrics:

Deon, Laura, MD	Pediatric Rehabilitation	Voluntary
Reappointment Effective:	August 16, 2016 thru August 15, 2018	
Rasamimari, Phornphat MD	Neonatology	Active
Reappointment Effective:	October 28, 2016 thru October 27, 2018	
Siffermann, Emily, MD	Child Abuse & Neglect	Active
Reappointment Effective:	October 21, 2016 thru October 20, 2018	
Arcia-Diaz, Rosibell, MD	Pediatrics	Active
Reappointment Effective:	November 13, 2016 thru November 12, 2018	

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APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON AUGUST 16, 2016

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications (continued)

Department of Psychiatry:

Clark, Laurel, MD	Psychiatry	Active
Reappointment Effective:	September 22, 2016 thru September 21, 2018	
Thomas, Lynelle, MD	JTDC	Voluntary
Reappointment Effective:	November 25, 2016 thru November 24, 2018	

Department of Radiology:

Camren, Gerald, MD	Radiology	Active
Reappointment Effective:	September 23, 2016 thru September 22, 2018	

Department of Surgery:

Conley, David, MD	Otolaryngology	Active
Reappointment Effective:	August 16, 2016 thru August 15, 2018	
Hasan, Jafar, MD	Plastic Surgery	Active
Reappointment Effective:	August 16, 2016 thru August 15, 2018	
Hollowell, Courtney, MD	Urology	Active
Reappointment Effective:	August 16, 2016 thru August 15, 2018	
Johnson, Donna, MD	Ophthalmology	Active
Reappointment Effective:	August 26, 2016 thru August 25, 2018	
Lygizos, Nicholas, MD	Otolaryngology	Consulting
Reappointment Effective:	August 16, 2016 thru August 15, 2018	
McDonald, Sarah, MD	Otolaryngology	Active
Reappointment Effective:	August 21, 2016 thru August 20, 2018	
Panos, George, DDS	Oral & Maxillofacial	Active
Reappointment Effective:	August 26, 2016 thru August 25, 2018	

Department of Trauma:

Poulakidas, Stathis, MD	Trauma Burn Unit	Active
Reappointment Effective:	September 6, 2016 thru September 6, 2018	

Renewal of Privileges for Non-Medical Staff:

Altez, Carlos C., PA-C	Correctional Health Srvcs	Physician Assistant
With Yu, Yan, DO		
Alternate Baker, Terrance, MD		
Effective:	August 26, 2016 thru August 25, 2018	
Falola, Eto, CNP	OB/GYN	Nurse Practitioner
With Burtch, Radha, MD		
Effective:	August 16, 2016 thru August 15, 2018	

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BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON AUGUST 16, 2016

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

John H. Stroger, Jr. Hospital of Cook County

Renewal of Privileges for Non-Medical Staff (continued):

Martinez, Salvador, PA-C With Richardson, Stamatia, MD Alternate Paul, Reena, MD Effective:	Correctional Health Srvcs August 26, 2016 thru August 25, 2018	Physician Assistant
Mathew, Lizamma, CNP With Sattar, Payman, MD Effective:	Medicine/Adult Cardiology August 16, 2016 thru August 15, 2018	Nurse Practitioner
Melvin, Amy, CNP With Muzaffar, Shirin, MD Effective:	Medicine/Pulmonary & Critical Care August 16, 2016 thru August 15, 2018	Nurse Practitioner
Naftzger-Kang, Lisa, CNP With Cintron, Jose R., MD Effective:	Surgery/Colon/Rectal August 16, 2016 thru August 15, 2018	Nurse Practitioner
Stadnicki, Christopher, PA-C With De Funiak, Andrew, MD Alternate Mennella, Concetta, MD Effective:	Correctional Health Srvcs August 16, 2016 thru August 15, 2018	Physician Assistant

Collaborative/Supervision Agreement Only:

Brooks, Cicely, PA-C With Gafoor, Sabiha, MD Alternate Ezike, Ngozi, MD Effective:	Correctional Health Srvcs/Psychiatry August 16, 2016 thru January 19, 2017	Physician Assistant

CCHHS
APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON AUGUST 16, 2016

Valerie Hansbrough, MD
President,
Medical Executive Committee
Provident Hospital
Of Cook County

August 5, 2016

Dear Members of the Quality and Patient Safety Committee:

Please be advised that at the Credentials Meeting held on August 2, 2016 the Medical Executive Committee of Provident Hospital of Cook County recommended the actions on the enclosed list. It is being presented to you for your consideration.

Respectfully,

Valerie Hansbrough, MD
President, MEC

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Provident Hospital of Cook County

Medical Staff and Non-Medical Staff Action Items subject to approval by the CCHHS Quality and Patient Safety Committee.

INITIAL APPOINTMENT APPLICATIONS

Adams, Carmen, MD Appointment Effective:	OB/GYN August 16, 2016 thru August 15, 2018	Affiliate
Painstil, Issac, MD Appointment Effective:	Internal Medicine September 16, 2016 thru July 12, 2018	Affiliate
Turner, Arnold, MD Appointment Effective:	Internal Medicine September 16, 2016 thru September 15, 2018	Active
Reiss, Benjamin, MD Appointment Effective:	Surgery/Ophthalmology August 16, 2016 thru July 18, 2018	Affiliate
Veenstra, Benjamin, MD Appointment Effective:	Surgery/General August 16, 2016 thru July 18, 2018	Voluntary
Apushkin, Michael, MD Appointment Effective:	Radiology August 16, 2016 thru August 15, 2018	Affiliate
Bugeag, Ionut, MD Appointment Effective:	Radiology August 16, 2016 thru April 18, 2018	Affiliate
Keen, John, MD Appointment Effective:	Radiology August 16, 2016 thru July 21, 2018	Affiliate

REAPPOINTMENT APPLICATIONS

Department of Internal Medicine

Gandhi, Seema, MD Reappointment Effective:	Gastroenterology October 28, 2016 thru October 27, 2018	Affiliate
Gueret, Renaud, MD Reappointment Effective:	Pulmonary October 17, 2016 thru June 28, 2018	Affiliate
Mullane, Michael, MD Reappointment Effective:	Hematology/Oncology August 16, 2016 thru August 15, 2018	Affiliate
Pelaez, Victor, MD Reappointment Effective:	Cardiology October 21, 2016 thru July 10, 2018	Active
Pierko, Krystof, MD Reappointment Effective:	Internal Medicine October 16, 2016 thru October 15, 2018	Affiliate
Warrior, Lakshmi, MD Reappointment Effective:	Neurology October 16, 2016 thru October 15, 2018	Affiliate

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APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON AUGUST 16, 2016

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Provident Hospital of Cook County
Reappointment Applications (continued)

Department of Surgery

Beck, Traci, MD	Surgery/Urology	Affiliate
Reappointment Effective:	August 26, 2016 thru August 25, 2018	
Hasan, Jafar, MD	Surgery/Plastic	Affiliate
Reappointment Effective:	August 16, 2016 thru August 15, 2018	
Hollowell, Courtney, DO	Surgery/Urology	Affiliate
Reappointment Effective:	August 16, 2016 thru August 15, 2018	
LaVeau, Robert, DPM	Surgery/Podiatry	Affiliate
Reappointment Effective:	September 16, 2016 thru September 15, 2018	
Pulla, Richard, DPM	Surgery/Podiatry	Affiliate
Reappointment Effective:	September 17, 2016 thru September 16, 2018	

Teleradiology

Bold, Johnathan, MD	Virtual Radiologic	Teleradiology
Privileges Effective:	August 21, 2016 thru August 20, 2018	

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APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON AUGUST 16, 2016